NOTICE OF INTENTION TO SUSPEND PAYMENT OF WORKERS' COMPENSATION BENEFITS

TO: _____ DOI:_____
Name of Claimant

_____ _____
Last known address Employee's last telephone #

_____

Dear

According to our records, we mailed a form WC53 requesting verification of your employment status to you on (date)_____. You had 30 days to return this form to us but to date we have not received it.

Enclosed is a blank copy of the form, please complete the form and return it to us no later than (date)_____.

**Under the law, failure to return the completed form by the date listed above may result in the suspension of payment of your benefits until such time as the form is completed and returned to this company.**

If you have questions, you may call (name of carrier)_____ at _____ and ask for _____
telephone number name of carrier representative

You may also contact the New Hampshire Department of Labor at (603) 271-3176, or 1-800-272-4353, and ask for Workers' Compensation claims.

Very truly yours,

_____

cc: Commissioner of Labor

53-A WC (12/2000)